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DEC 10 1996

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IN THE
Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—against—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.;
and HOWARD A. GROSSMAN, M.D.,

Respondents,

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE,
ATTORNEY GENERAL OF WASHINGTON,

Petitioners,

—against—

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D.,
THOMAS A. PRESTON, M.D., and PETER SHALIT, MD. PH.D.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT
OF APPEALS FOR THE SECOND CIRCUIT AND NINTH CIRCUIT

**BRIEF OF AMICUS CURIAE BIOETHICISTS
SUPPORTING RESPONDENTS**

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QUESTION PRESENTED

Whether physicians, following the scruples of their individual consciences, may ethically respect the competent, voluntary and informed requests of terminally-ill patients to be relieved from their pain and suffering by assisting them in hastening otherwise inevitable death?

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INTEREST OF THE AMICUS CURIAE

Bioethics, a learned discipline that arose approximately twenty-five years ago, deals "with ethical questions that arise as a result of advances in medicine and biology." OXFORD ENGLISH DICTIONARY (new ed.).

The bioethicists supporting Respondents in Vacco, et al. v. Quill, et al., No. 95-1858 ("Quill") and State of Washington v. Glucksberg, et al., No. 96-110 ("Glucksberg") are professors, lawyers, and medical doctors who have written and lectured extensively, and are considered among the nation's pre-eminent experts on the narrow issue before the Court.¹ Many of them hold multiple advanced degrees and occupy distinguished positions at universities and medical centers. They are identified at Appendix A.

The amicus group of bioethicists strongly believes that physicians, in carrying out their ethical duty to relieve the pain and suffering of their terminally-ill patients, should be legally permitted to accede to the desire of a patient to hasten death when the patient's decision is voluntarily reached, a patient is competent to make the decision, and the patient has been fully informed of the diagnosis and prognosis of an incurable, fatal disease which has progressed to the final stages. The amicus group also strongly believes that a physician may decline to honor such a request if it violates the physician's beliefs, morals or scruples or is contrary to the physician's medical judgment. The amicus group believes that the right to physician-assisted suicide should be recognized by this Court as a fundamental right, as the Court of Appeals for the Ninth

¹ The bioethicists supporting Respondents have received the consent of the parties in Quill and Glucksberg to file this Amicus Curiae brief. The consents are being filed with the Court simultaneously with this brief.

Circuit ruled in Glucksberg. Moreover, the amicus group agrees with the Court of Appeals for the Second Circuit in Quill that the denial of physician-assisted suicide is a denial of equal protection to terminally-ill patients who do not have the option of hastening death by requesting the removal of life support systems.

These views are rooted in the four basic principles of biomedical ethics: autonomy, nonmaleficence, beneficence, and justice. Beauchamp and Childress, Principles of Biomedical Ethics (4th ed. 1994). From these principles, articulated in various ways in differing ethical systems, arise the two considerations most basic in medical care: the patient's fundamental right of self-determination and respect for the patient's interests. "Deciding To Forego Life-Sustaining Treatment," President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (March, 1983). Ethical requirements of respect for the patient's right of self-determination and respect for the patient's interests appropriately guide all care of patients, including the care of dying patients. Dan W. Brock, "Voluntary Active Euthanasia," Hastings Center Report 22:2 (March-April 1992) 10-22.

ARGUMENT

THIS COURT SHOULD RECOGNIZE A RIGHT TO PHYSICIAN-ASSISTED SUICIDE FOR COMPETENT DYING PATIENTS

Petitioners and their supporting amici have presented arguments that far exceed the understanding of physician-assisted suicide as approved by the Second and Ninth Circuit Courts. They argue that permitting physician-assisted suicide for terminally ill patients who seek to end their suffering in the final stages of degenerative diseases will lead to the involuntary killing of terminal patients and the healthy mentally ill and disabled.

These arguments are entirely flawed. The institution of safeguards to prevent abuse is necessary, but there is no basis to conclude that a voluntary practice limited to terminally-ill patients would be involuntarily applied, or that it could be imposed upon incompetents.

Petitioners and their amici also attempt to exploit taboos associated with suicide, citing, for example, instances of suicide among the depressed or mentally ill. The cases before this Court, however, do not involve sanctioning suicide of depressed or mentally-ill individuals.

Unlike other cultures, our language has but one word to describe self-inflicted death. The word "suicide" does not differentiate among the deaths of a teenager overcome by the struggles of adolescence, a middle-aged family man facing financial ruin and an eighty-year old cancer patient who seeks to avoid further protracted pain and suffering when her death is near. Unlike the first two tragic illustrations, there can be a sense of meaningfulness, emotional resolution, and communicative culmination, including gratitude for a life now complete, in the "suicide" of the dying patient who seeks both to avoid a bad death and to bring life to an inevitable but appropriate close. The dying patient may act to avoid or relieve suffering, and may also seek to meet death at a time and place of his or her own choosing, surrounded by those whom he or she trusts and loves, while still conscious and still capable of prayer and farewells. The right to seek a death which is both free of pain, but faced while conscious and alert, is not a trivial right, but one of great significance for many people.

The common term "suicide" carries strongly negative associations that have no bearing on the issue before the Court, but are largely derived from medieval attitudes towards violent self-destruction. Battin, The Death Debate: Ethical Issues in Suicide (1996). It would have been more accurate if the debate on

this issue had been joined on physician-assisted "death" as distinct from physician-assisted "suicide."

**The Prevalence Of Death From
Degenerative Disease Is A Modern
Problem Not Addressed By Antiquated Laws**

Petitioners stress the long tradition of prohibition against suicide, including penal laws dating to the founding of this country. But such laws derive from a time when death was rarely preceded by long periods of physiologically degenerative suffering. At the time the Constitution and the Bill of Rights were written and throughout the development of English common law, the process of dying was usually quick and more likely to be due to infectious disease. Medical intervention did little to prolong life, or to prolong the process of dying. The cases before the Court, however, involve degenerative death, a creature of modern medicine; they should therefore be decided on an historically clean slate. The Court, in finding for Respondents, would not be judicially mandating social change; it would be applying constitutional doctrines of protected individual rights to a new factual situation.

Epidemiologists identify four distinct periods to describe mortality and longevity in the history of mankind. In the Age of Pestilence and Famine, which extended from the dawn of human existence to approximately 1850, people died primarily from infectious and parasitic diseases, frequently exacerbated by famines and plagues. Advances in public sanitation, immunization and antisepsis in medicine gave rise to the Age of Receding Pandemics, which lasted until approximately 1920 and was accompanied by an increase in life expectancy. In the period from 1920 until 1960, the Age of Degenerative Man-Made Diseases, advanced surgical techniques, antibiotics, techniques for the administration of intravenous fluids and drugs, the development of respiratory support systems and improved therapeutic and diagnostic techniques further increased life expectancy. Omran, "The Epidemiologic Transition:

A Theory of the Epidemiology of Population Change," Milbank Memorial Fund Quarterly 49 (4):509-38 (1971). Epidemiologists characterize the current state of mortality and life expectancy, which arose in the mid 1960's, as the Age of Delayed Degenerative Diseases, in which the majority of people die at later ages from degenerative diseases, such as cancer, heart disease, stroke and neurological diseases. Olshansky and Ault, "The Fourth Stage of the Epidemiologic Transition: The Age of Delayed Degenerative Diseases," in Timothy M. Smeeding, et al., eds. Should Medical Care Be Rationed By Age? (1987) 11-43.

These epidemiological changes are partly illustrated by the changes in life expectancy. At the turn of this century, American life expectancy at birth was 46.5 years for males and 49 years for females. Life expectancy at birth is now approximately 72 years for males and 79 years for females. Life Tables for the United States 1900-2050, Social Security Administration, SSA Pub. No. 11-11534. But these advances in life expectancy are associated with a fundamental change in the way we die: throughout the developed world of the late 20th century, including the United States, the majority of the population will die of degenerative disease. About a third of deaths are due to circulatory disease; another third are due to cancer; and the remaining third include degenerative conditions like neurological diseases and various forms of organ failure. The modern form of degenerative death is estimated to account for 70-80% of all deaths in the United States. Battin, The Death Debate, at 178.

Not only do these deaths from degenerative disease tend to occur at more advanced ages than has been characteristic of earlier periods of human mortality, but particularly in the case of cancer, they are often accompanied by protracted periods of pain and suffering before death, a phenomenon which occurred comparatively rarely until recent years. Prior to the development of modern antibiotics, the patient whose condition deteriorated severely or who became bedridden was likely to contract pneumonia

or other infections and die, thus being naturally spared the most difficult phases of end-stage disease.

The issue of physician-assisted suicide should be decided on the basis of present realities and not by reference to antiquated laws and customs adopted long before the modern form of degenerative death became prevalent. Neither the framers of the Constitution, nor any previous legal authorities, could have foreseen the way most people now die.

Classical Medicine Recognized A Patient's Right To Physician-Assisted Suicide

In Quill, petitioners cite one version of the Hippocratic Oath which contained the prohibition: "To please no one will I prescribe a deadly drug, nor give advice which may cause his death." Petitioners seem to suggest that the Oath has the force of law, but the version they cite also prohibits a number of medical practices clearly and uncontroversially recognized as legal, including surgery and charging fees for teaching medicine, as well as practices explicitly recognized as legal by this Court, such as abortion.

The Hippocratic Oath can only be understood in its historical context. At the time of Hippocrates, there was no prohibition against physician-assisted suicide in mainstream Greek medicine; the practice was subject to consultation and informed consent similar in intent to the protocols urged by medical professionals and bioethicists today. Thus, at the time of Hippocrates:

...the taking of poison was the most usual means of committing suicide [in terminal illness], and the patient was likely to demand the poison from his physician who was in possession of deadly drugs and knew that which brought about an easy and

painless death. On the other hand, such a resolution was not taken without due deliberation, except perhaps in a few cases of great distress or mental strain. The sick man wished to be sure that further treatment would be of no avail, and to render this verdict was the physician's task. The patient, therefore, consulted with him, or urged his friends to speak to the doctor. If the latter, in such a consultation, confirmed the seriousness or hopelessness of the case, he suggested directly or indirectly that the patient commit suicide.... [I]n antiquity many physicians actually gave the patients the poisons for which they were asked.

Ancient Medicine: Selected Papers of Ludwig Edelstein, Owsei and C. Lillian Temkin, eds. (1967) 11-13. See also, Amundsen, "The Physician's Obligation to Prolong Life: A Medical Duty Without Classical Roots," Hastings Center Report (August 1978) 23, 26-27 (Hippocratic Oath is an "esoteric document that is often inconsistent with the larger picture of Greco-Roman medical ethics."); Gourevitch, "Suicide Among the Sick in Classical Antiquity," Bulletin of the History of Medicine 43 (1969) 501, 506-08.

Adherents of the Hippocratic school of medicine were strongly influenced by Pythagoras. Not unlike contemporary adherents of natural cures for disease, he eschewed many then-mainstream, accepted medical practices. The original Greek version of the Oath, quoted by the Quill petitioners, required the followers of Hippocrates:

to teach them this art--if they desire to learn it --
without fee and covenant;

* * *

[to] apply dietetic measures for the benefit of the

sick according to my ability and judgment;

* * *

not [to] give to a woman an abortive remedy

* * *

not [to] use the knife....

Ancient Medicine at 6.

The text of the Hippocratic Oath has been modified many times through the ages. Contemporary versions, routinely adopted in medical-school graduation exercises and similar contexts (see text of Oath adopted by World Medical Association in 1948 reproduced at Appendix B), do not contain the prohibitions against surgery, abortion, or accepting fees for teaching medicine, and also omit the prohibition against physician-assisted suicide. In short, neither the Hippocratic Oath nor classical tradition provides a compelling ethical or professional prohibition of physician-assisted suicide.

**Petitioners Have Not Advanced
Sufficient Interests To Overcome
The Right Of A Terminally-Ill
Patient To Assisted Death**

The States of New York and Washington argue that the government has an overriding interest in the preservation of life which is not subject to veto by the individual wishes of dying patients. Similarly, the American Medical Association and other amici supporting Petitioners contend that physicians are devoted to the healing arts and should not be involved in the termination of life.

Not only is there no adequate basis for either of these claims, but the AMA's position does not even reflect the views or practices of its constituency. In fact, physicians are divided about this issue, and many support the recognition of a patient's right to assistance and reject state interference in their right to practice medicine in a way they see as humane, compassionate, and respectful of the wishes of their dying patients. As reported in The New England Journal of Medicine, 60 percent of doctors in Michigan and 66 percent of doctors in Oregon -- two states in which this issue has been very widely discussed -- support legalizing assisted suicide for terminally-ill patients. Lee, et al., "Legalizing Assisted Suicide -- Views of Physicians in Oregon," New England Journal of Medicine 335:5 (Feb. 1, 1996) 310-315, at 311; Bachman, et al., "Attitudes of Michigan Physicians and of the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia," New England Journal of Medicine, 334:5 (Feb. 1, 1996) 303-309, at 303. In the State of Washington, 12 percent of physicians polled reported that they had been asked by their terminally-ill patients for prescriptions to hasten death, and of these, 24 percent had complied with such a request in the year prior to the study. Bach, et al., "Physician Assisted Suicide and Euthanasia in Washington State," Journal of the American Medical Association 275:12 (March 27, 1996) 919-925 at 919.

Assertions that doctors should have no role in death fly in the face of reality. All people eventually die, and the doctor's role appropriately includes ensuring that the patient's death occurs as humanely as possible. As Francis Bacon wrote, the physician's role is to help the patient "make a faire and easie passage."

The humaneness of a death is not only a matter of avoiding pain and physical suffering; it is also a matter of consonance with a patient's most basic values. For some patients, a death softened by the heavy use of painkillers or hastened by withholding or withdrawing life-sustaining treatment will be tolerable; for others such prospects are profoundly repugnant: these patients fear and

resent a death preceded by a period of obtundation, or in which their bodies slowly deteriorate from the ravages of a lethal disease. Not all patients will choose to die in the same way, even when death is imminent: some will prefer continued aggressive treatment, in the hope that they can beat the odds; some will prefer withdrawing or withholding specific forms of treatment; others will accept death as a consequence of escalating doses of morphine; still others will choose to forego nutrition and hydration; some will tolerate terminal sedation; but some strongly prefer a peaceful and humane death directly initiated while conscious and alert, facilitated by the assistance of a physician.

Physician-assisted suicide is not an option likely to be chosen by many. In the Netherlands, where assistance in dying is openly practiced and widely accepted, less than 3.5% of patients dying in a given year chose this manner of death. Yet it can be of very great moral and spiritual importance to those who make this choice. It may be the privilege of religious traditions to reject such a practice, as several of the Petitioners' amici point out, but it is not their privilege to assert that such an act on the part of a dying patient must be devoid of personal or spiritual significance.

Petitioners and their amici repeatedly assert the state's interest in preservation of life. This interest, however, is necessarily subject to careful qualification. Washington and New York have capital punishment statutes, permitting state-sanctioned death of otherwise healthy individuals. Revised Code of Washington 9A.32.030; New York Penal Law Section 60.06. The state, in times of war, sacrifices the lives of its most vital citizens to the national interest. Because the state approves of the deaths of individuals when it serves its interests, the state cannot advance an absolute objection to participation in death as an answer to claims that terminally ill patients have a right to seek and accept assistance from their physicians in suicide. The state clearly does have an interest in preventing suicide that is impulsive, aggressive, irrational, violent, or coerced, or where the suicidal impulse arises

from depression or other mental illness; but the state does not have an interest in preventing a competent patient, who is in any case facing death, from rationally and reflectively choosing what to that person is the preferable way of meeting death. It is the overly broad, unwarrantedly negative connotations of the term "suicide" that obscure this crucial distinction.

Virtually all data about the causes and characteristics of suicide and its relationship to mental illness, cited by several of Petitioners' amici, is data only about suicides in the former sense. Although rational, reflective suicides do occur in terminal illness, often assisted by physicians, they are virtually never reported as suicides, and it has thus been impossible to collect reliable data about these latter "suicides." Suicide is often said to be about the choice between life and death. Glucksberg and Quill, however, are not cases about patients choosing between life and death. They are about patients choosing death in a way that seems to them dignified, humane and more in keeping with their basic values, rather than what seems to them a less desirable and undignified death.

In a lengthy footnote, the Bioethics Professors' Amicus Curiae Brief Supporting Petitioners argues that physicians have no fear of prosecution if they prescribe drugs which a patient subsequently uses to commit suicide, provided the physician is not present when the patient takes the lethal medication. Brief For Bioethics Professors Amicus Curiae Supporting Petitioners at 15-16 n. 6.² Even if that were the case, maintaining such a status quo

² We too, believe that this act should not be regarded as a criminal one, provided the prescription is provided at the voluntary request of a competent, fully informed patient. We particularly welcome these bioethicists' tacit recognition that some dying patients will prefer a directly-caused death and that some physicians will be willing to provide the means for it, since it counters the quite trivializing claim from other amici that the use of opiates, of

would be unsatisfactory. Physicians do not generally believe that they would be free from prosecution and they are often reluctant to assist patients who wish to die with dignity; it is at best a legally controversial claim. Because current statutes criminalizing assisted suicide contain no exemption for physicians, doctors are often constrained to abandon their patients at their time of greatest need. Even when a doctor prescribes the necessary drugs he or she often refuses to assist the patient in using the drugs. Unaided by professional assistance, an already suffering patient in the process of dying may take the medication improperly, survive, and undergo still more substantial suffering from unwanted, sublethal complications. Lonny Shavelson, A Chosen Death: The Dying Confront Assisted Suicide, (1995).; Stephen Jamison, Final Acts of Love: Families, Friends, and Assisted Dying (1995). Such profoundly unwanted events are not uncommon among "amateur" assisted suicides.

The bioethics professors supporting Petitioners erroneously believe that medical ethics is advanced by a practice where a physician and patient are encouraged to conspire covertly to circumvent the law, but where the patient is then denied medical assistance at the time of death and left to suffer the consequences of inadequate procedures. The bioethicists who are signators of the present brief believe strongly that medical ethics and trust in physicians are better served by physician-assisted suicide where the patient can have the care, comfort and treatment of his or her doctor at the time the patient acts to hasten death.

The argument of the Bioethics Professors in Support of Petitioners also misinterprets the medical facts of dying. Their brief, addressing the equal protection argument in Quill, attempts

discontinuing life sustaining treatment, of withholding nutrition and hydration, and of terminal sedation are sufficient answers to the patient's distress.

to differentiate between patients on life support and those who are not. Those on life support are different, they argue, because of a bodily intrusion that could only have taken place with their consent, which consent they can withdraw at any time. They further claim that a terminally-ill person who is not on life support is differently situated for equal protection analysis because he or she is not being subjected to an ongoing physical intrusion. But this argument is erroneous. Both types of patients have had bodily intrusions for which they have given consent. A patient gives consent for a ventilator, or a feeding tube, and can then withdraw that consent and the bodily intrusion. Another patient gives consent for chemotherapy, a bodily intrusion which changes him or her unalterably, and ultimately leaves the patient in a condition of dying quite differently from that without the chemotherapy; yet the patient cannot withdraw that bodily intrusion, since it has already irreversibly occurred. Patients not connected to life support are therefore not free from bodily intrusion, and patients who are connected to life support do not die "naturally" if that support is removed. Once life has been prolonged with any sort of therapy, the mode of dying is unnatural; irreversible physical intrusion has already occurred. The Second Circuit Court of Appeals correctly rejected the claim that there is a rational distinction between refusing treatment and suicide.

Protocols and Guidelines May Be Imposed To Avoid The "Slippery Slope"

This Court has recognized the rights of individuals to make major life decisions regarding the integrity of their bodies, Roe v. Wade, 410 U.S.113 (1973); Planned Parenthood of Southeastern Pennsylvania v. Casey, 502 U.S. 1056 (1992), including the right of the terminally-ill to determine the end of their lives. Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990). In all of these cases, the Court has carefully delineated the rights in question and stated that they are subject to reasonable regulation.

Roe v. Wade, *supra*, 410 U. S. at 163 ("a state may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health."); Planned Parenthood v. Casey, *supra*, 505 U.S. at 872 ("Though the woman has a right to choose to terminate or continue her pregnancy before viability, it does not follow at all that the State is prohibited from taking steps to ensure that the choice is thoughtful and informed"); Cruzan, *supra*, 497 U.S. at 281 ("The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements.").

Despite the history of caution by this Court in delineating rights with respect to life and death decisions, Petitioners and their amici contend that the Court's recognition of a right of competent, terminally-ill patients to obtain physician-assisted suicide will lead down a slippery slope such that its holding will lead to involuntary deaths or physician-facilitated deaths of the incompetent.

There is no basis to believe that physician-assisted suicide will lead to such abuses. Safeguards would obviously be devised to protect against abuse. Examples of such safeguards, the details of which are the appropriate concern of the states in regulating the exercise of patients' constitutionally-protected basic rights, are available both in this country and abroad. For example, the Oregon Death With Dignity Act, which by its terms is limited to competent adults who have been determined by the attending physician to be suffering from a terminal disease, requires two oral and one written request from the patient witnessed by two individuals to the effect that the patient is competent, acting voluntarily and is not being coerced to sign the request; requires the physician to inform the patient of his or her medical diagnosis and prognosis, the potential risks in, and probable results from, taking the medication; requires that the physician inform the patient of the feasible alternatives, including comfort care, hospice care, and pain control; requires that

the patient be referred to a consulting physician for confirmation of the diagnosis and determination that the patient is competent and acting voluntarily; requires that the patient be referred for counseling if appropriate; imposes a fifteen-day waiting period; and requires that the attending physician provide full documentation demonstrating compliance with the Act. It permits the patient to rescind the request at any time, in any manner.

Similarly, the Dutch guidelines for physician-assisted suicide require that the patient make a voluntary, enduring request; that the patient have adequate information about his or her disease, including alternative methods of treatment; that the patient's suffering be intolerable, in the patient's view, and irreversible, without alternatives for relieving the suffering that are acceptable to the patient; that the attending physician exercise due care in reviewing and verifying the patient's condition; that there be a consultation with a second, independent physician; and that the physician who provides assistance in hastening death file a written report of the death, which may not be reported as a natural death. Battin, The Least Worst Death (1994) at 131. Angel, "Euthanasia in the Netherlands -- Good News or Bad?" New England Journal of Medicine 335:22 (Nov. 28, 1996) 1676.

We believe such safeguards will provide patients clearly adequate protection against pursuing physician-assisted suicide from impulse, irrationality, depression, misinformation, manipulation, or coercion. They constitute reasonable means of assuring voluntary choice, of ruling out mental illness, of preventing mistaken diagnoses or faulty prognostications of terminal illness, of detecting familial, professional, or institutional pressures on the patient, of assuring that the practice actually serves the patient's interests, of protecting against the devaluation of members of minorities or disabled or medically dependent people, or in other ways protecting the patient's basic rights. Abuses are equally possible when treatment is withheld or withdrawn, when dosages of painkillers are used which foreseeably

depress respiration and so hasten death, when nutrition and hydration are withdrawn, when do-not-resuscitate orders are written, and when other commonplace strategies of "negotiated" death are employed. While there is no credible evidence that these possible abuses are in fact occurring to any significant degree, the safeguards to be erected for the protection of patients in the matter of physician-assisted suicide should operate to provide greater assurance of full voluntariness and full information, and, by requiring reporting, would allow surveillance of the practice to discover and penalize physicians or others who do not adhere to regulatory restrictions. Battin, "Voluntary Euthanasia and the Risks of Abuse," in Battin, The Least Worst Death, 163-181.

Petitioners and their amici claim that the experience of the Netherlands in permitting physician-performed euthanasia and physician-assisted suicide shows the substantial risks of a "slippery slope," where legalization or legal toleration of directly caused death leads to widespread unacceptable killing. Many of their claims are empirically false and grossly distorted. There is no evidence of conscious, competent patients being euthanasized against their will.³

³ In the majority of cases, a patient's current, explicit request, fitting the guidelines cited above, is in force at the time of assistance in suicide or euthanasia. In a fraction of cases (0.7%), there is no current explicit request; in about half of these cases (including all competent patients), either the decision was discussed with the patient earlier in the illness or the patient had expressed a wish for euthanasia if suffering became unbearable. In the other cases the patient was incompetent. In 91% of these cases, life was shortened by a week or less (in a third, 24 hours or less), and in the small number with longer life expectancy, the patient was evidently suffering greatly but verbal contact was no longer possible. Van der Maas et al., "Euthanasia, Physician-Assisted

Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995," New England Journal of Medicine 335:22 (Nov. 28, 1996), 1699, 1701-1702. Loes Pijnenborg et al., "Life-Terminating Acts Without Explicit Request of Patient," The Lancet 341 (May 8, 1993) 1196-1199.

New evidence from the Netherlands, based on studies which repeated the initial empirical studies of euthanasia and physician-assisted suicide known as the Remmelink report, show that reporting has increased and the frequency of cases regarded as problematic has decreased. The number of cases has increased in association with the aging of the population and an increase in the proportion of deaths from cancer, a function of the decrease in deaths from ischemic heart disease, but the proportion of requests granted has decreased. (Indeed, most requests for euthanasia or assistance in suicide are not granted.) Physician-assisted death does not involve patients whose illnesses are less severe, nor are there any signs that the decisionmaking has become less careful -- rather, there is more frequent consultation and better documentation. Van der Maas, supra, at 1703, 1705; Gerrit van der Wal et al., "Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands," New England Journal of Medicine 335:22 (Nov. 28, 1996), 1706-1711.

In the view of the researchers, "these data do not support the idea that physicians in the Netherlands are moving down a slippery slope," Van der Maas, supra, at 1705, a view echoed by the Executive Editor of the New England Journal of Medicine. Marcia Angel, MD., Editorial: "Euthanasia in the Netherlands -- Good News or Bad?" New England Journal of Medicine 335:22 (Nov. 28, 1996), 1676-1678, at 1677. Physician-assisted death continues to account for less than 3.5% of all reported deaths: thus the vast majority of patients dying in a given year do not choose it, and even the vast majority of cancer patients -- the most frequent

The Right of Competent, Dying Patients to Physician-Assisted Suicide is a Negative Right To Be Free from State Interference

In Glucksberg, the Ninth Circuit Court of Appeals held that physician-assisted suicide is a fundamental liberty right. This right to determine one's own mortality shares one important characteristic with other fundamental rights. Like the rights to vote or to worship, there is no requirement that the right be exercised. Joel Feinberg, "Voluntary Euthanasia and the Inalienable Right to Life," Philosophy and Public Affairs 7, no. 2 (Winter, 1978).

Similarly, under neither Glucksberg nor Quill would a physician be required to accede to a request for suicide assistance if the request violates the doctor's personal, medical or religious beliefs. The constitutionally-protected right asserted in these cases is, as bioethicists would put it, a negative right, a right not to be interfered with, a true liberty-right. Neither case asserts a positive right or claim-right, a demand that patients could make upon physicians whether physicians felt it medically or morally appropriate to respond or not. Thus, the full and appropriate scope of a physician's rights as well as a patient's rights would be recognized, since the physician would no longer be legally constricted in caring for a terminally-ill patient where that patient sought help in hastening death, though he or she would not acquire any new or unwanted obligation, and the full range of a patient's traditional, constitutionally-protected liberty rights of self-determination would be recognized in the new factual circumstance of the modern form of degenerative death.

diagnosis — do not. Yet it remains widely regarded as an important option even if one rarely needed or utilized.

Recognition of a protected right to seek and accept assistance in suicide from a willing physician is not only important for the comparatively small number of terminally-ill patients who might actually use it. Those patients who do not choose to exercise their right to physician-assisted suicide may gain comfort in the knowledge that the option exists if their suffering becomes intolerable. For many, this will make it possible to live fuller, more complete, lives during the process of dying, since they need not fear a bad death. Timothy E. Quill, M.D. "Death and Dignity: A Case of Individualized Decision Making." The New England Journal of Medicine 324:10 (March 7, 1991), 691-694. Indeed, the possibility of physician-assisted suicide, even if never used, may contribute positively to the quality of life for those facing death.⁴

The records before this Court contain the testaments of the individual, suffering plaintiff-patients — all of whom died without the desired assistance of their physicians in terminating their pain and suffering and without the knowledge that the Courts of the Ninth and Second Circuits would respond to their anguished pleas. Their tales of agony could be reiterated many thousand times over, but may be summarized by the final note of the Nobel Prize-winning physicist, Percy Bridgman, who nearly 80 years old and suffering from terminal cancer, shot himself. His note stated:

⁴ A 1994 Australian study of cancer patients found that those who anticipated a role for the more active options of suicide and/or euthanasia in their own futures, compared to those who anticipated a future possible role for only the more passive options of wishing death to come early or ceasing all treatment, were more hopeful and reported a higher quality of life than patients who regarded them as out of the question. Owen, et al., "Cancer Patient's Attitudes to Final Events in Life: Wish for Death, Attitudes to Cessation of Treatment, Suicide and Euthanasia," Psycho-Oncology 3:1-9 (1994).

It isn't decent for society to make a man do this thing himself. Probably this is the last day I will be able to do it myself.

Percy Bridgman, letter in Bulletin of the Atomic Scientists, quoted by Max Delbruck, "Education for Suicide," interview in Prism, a publication of the American Medical Association, 2 (1974) 20.

CONCLUSION

Affirmation of the decisions below will contribute to a more decent society, more respectful of patients' basic rights and interests in the light of the realities of the modern form of degenerative death. We strongly urge that they be affirmed.

Dated: New York, New York
December 9, 1996

Respectfully submitted,

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APPENDICES

APPENDIX A

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APPENDIX B

THE OATH OF HIPPOCRATES

I solemnly pledge to consecrate my life to the service of humanity. I will give respect and gratitude to my deserving teachers. I will practice medicine with conscience and dignity. The health and life of my patient will be my first consideration.

I will hold in confidence all that my patient confides in me. I will maintain the honor and the noble traditions of the medical profession.

My colleagues will be as my family. I will not permit considerations of race, religion, nationality, party politics, or social standing to intervene between my duty and my patient. I will maintain the utmost respect for human life.

Even under threat I will not use my knowledge contrary to the laws of humanity. These promises I make freely and upon my honor.

Approved by the World Medicine Association in 1948.